

PAYMENT AND SYSTEM REFORM

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Program Goals

The Program on Payment and System Reform is a key component of The Commonwealth Fund's efforts to inform health reform policy. It supports the development and analysis of options for reforming how health care is paid for, focusing on incentives to improve the effectiveness and efficiency of care delivery while curbing spending growth. Activities sponsored by the program include:

- examining reforms that would align incentives and provide a base for more comprehensive payment reform;
- modeling the potential impact of alternative payment reform options within the Medicare program and throughout the health care system;
- studying how payment reform could stimulate new models of health care delivery that yield better, more coordinated care; and
- evaluating the potential for broader application of successful payment and delivery models.

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A Private Foundation Working Toward a High Performance Health System

The Issues

National spending on health care in the United States—which already has the most expensive health system of any country—is projected to nearly double over the next decade, from \$2.6 trillion in 2010 to \$4.6 trillion, or 20 percent of the gross domestic product, by 2020. Yet the resources spent on health care have failed to produce commensurate returns in access, outcomes, or value. There is growing agreement that many of the cost and quality problems in our health system today are caused, or at least exacerbated, by the way we pay for care. It has become clear that new approaches to paying for health care are needed so that providers are rewarded for the high value of their care rather than the volume of services they deliver, and so that working together to deliver more appropriate, coordinated, and effective care is rewarded, rather than punished—as it often is in the current system.

In addition to its provisions for making health insurance coverage available to millions of uninsured Americans, the Affordable Care Act establishes a foundation for identifying, developing, implementing, testing, and spreading new payment approaches. To aid this effort, policymakers will need information and analysis on the available alternatives, as well as the potential and actual impacts on health care utilization, spending, and quality.

Recent Projects

Developing Alternative Approaches to Health Care Payment and Delivery

Although a variety of payment reforms have been proposed, many are seen as either doing too little to make an appreciable impact, or changing payment too radically to implement without great disruption to health care providers. In *Transitioning to Accountable Care*, a 2011 report published by the Center for Health Care Quality and Payment Reform with Commonwealth Fund support, Harold Miller, Ph.D., calls for flexible, “middle ground” options that promote accountability for care yet do not force providers to take on more financial risk than they can manage or be held accountable for services they cannot effectively control. He identifies and describes three types of payment changes that could help primary care and specialty physician practices transition toward more global payment structures, and the central issues that must be addressed in implementing these changes.

The Affordable Care Act has been both a source and a catalyst for innovative approaches to payment reform and care delivery, as well as for new ways to measure performance and value and increase use of health information technology. One such innovation is the Medicare Shared Savings Program, which provides financial incentives for “accountable care organizations” (ACOs) to provide their patients with coordinated, well-integrated, and efficient care. Although many providers and payers are now preparing to participate

in ACOs, little known about what it takes for ACOs to succeed, including the payment models—from shared savings to shared risk—that will most appropriately support them. A July 2011 [Commonwealth Fund report](#) prepared by Catalyst for Payment Reform, in partnership with Booz Allen Hamilton, examined the formation of eight private accountable care organizations that use, or are planning to deploy, a shared payer–provider risk payment model. The study team, led by Suzanne Delbanco, Ph.D., emphasizes that continued experimentation with both shared-savings and shared-risk arrangements in the private sector will be critical in the search for successful ways to align incentives for high-value care.

In a complementary Fund-supported effort, Michael Bailit, M.B.A., and Christine Hughes, M.P.H., of Bailit Health Purchasing, interviewed payer and provider organizations and state agencies involved in shared-savings arrangements about their diverse approaches, including populations and services covered, assignment of providers, use of risk adjustment, and methods for calculating and distributing savings. In their issue brief, *Key Design Elements of Shared-Savings Payment Arrangements*, the authors identify the issues that payers and providers must still resolve, including how to determine whether savings were truly achieved, how to equip providers with the data, tools, and guidance they need, and what standard provider performance measures should be used.

Models for Transforming the Health Care System

The Physician Group Incentive Program (PGIP) is a collection of practice transformation and quality improvement initiatives in Michigan striving to improve the quality of patient care across the state. Developed collaboratively by Michigan physicians, their medical groups, and Blue Cross Blue Shield of Michigan, the PGIP works within the existing fee-for-service payment system to support, recognize, and reward practice performance and improvement among the more than 11,000 participating physicians. Incentive payments are tied to key outcome measures, including evidence-based recommendations for care processes and population-based cost measures, and support physician organizations’ efforts to acquire patient-centered medical home capabilities. The Commonwealth Fund is supporting an evaluation of the PGIP by a team at the University of Michigan, led by Christy Lemak, Ph.D. The study is examining the initiatives developed as part of the program, the implementation of those initiatives, how providers are responding, and the impacts on the quality and costs of care.

In Massachusetts, meanwhile, Blue Cross Blue Shield—the state’s largest commercial payer—is trying out a global payment model called the Alternative Quality Contract (AQC), which pays health care providers a comprehensive, global payment rather than

reimbursing them on a fee-for-service basis. The payment covers the entire continuum of a patient's care, including inpatient, outpatient, rehabilitation, long-term care, and prescription drugs, and providers are eligible for a performance bonus if they meet certain quality targets. With Commonwealth Fund support, a team led by Michael Chernew, Ph.D., of Harvard Medical School is evaluating the AQC's impact on health care utilization, spending, and quality of care. Initial findings of the evaluation indicate somewhat lower medical spending and improvements in both chronic and pediatric care.

The Premier Healthcare Alliance offers another model for health care organizations seeking to control costs and improve patient care. Premier, which began as a hospital purchasing collaborative, has formed a collaborative of 25 health systems that are forming accountable care organizations and pursuing the goals of better health, better care, and lower costs. For ACOs to flourish nationally, health care organizations will need guidance in designing and implementing ACOs while achieving those objectives. Under the direction of Eugene Kroch, Ph.D., and Danielle Lloyd, M.P.H., Premier is helping providers undergo the transformation by demonstrating how the more than 60 candidate members of its accountable care collaborative are seeking to acquire the infrastructure and capabilities of a successful ACO, including payment mechanisms, data systems, and performance measurement and improvement strategies. The project team is also performing an inventory of members' core capabilities as part of an assessment of ACO readiness.

Transformative health system change is also occurring on a statewide scale. In May 2011, Vermont became the first state to enact a law mandating a single-payer health care financing system—a system intended to achieve both universal health insurance coverage and greater control over costs. Supported in part by The Commonwealth Fund, William Hsiao, Ph.D., of Harvard University and his research team modeled alternative health care financing options for Vermont's legislature. In a July 2011 article in *Health Affairs*, Hsiao and colleagues provide [estimates of savings, costs, and impacts](#) of the historic legislation. According to their projections, the law will produce annual savings of 25.3 percent compared with current spending, cut employer and household spending by \$200 million, create 3,800 jobs, and boost the state's overall economic output by \$100 million. The article also recounts the political, legal, fiscal, and institutional hurdles that had to be surmounted, the strategies used to overcome them, and the factors that were integral to the law's passage.

Future Directions

In the coming year, the Program on Payment and System Reform will further develop the capacity to model the potential provider- and system-level impact of changes to health care payment and delivery, including those called for in the Affordable Care Act. The projects it supports will also identify ways to improve the process of rapid-cycle development, testing, and implementation of payment and system improvements, with which the new Center for Medicare and Medicaid Innovation is charged, and evaluate local initiatives to restructure payment incentives and improve health care delivery.

Commonwealth Fund-supported work also will examine how public and private initiatives can help reinforce each other. For example, the Affordable Care Act contains several provisions designed to make private Medicare Advantage insurance plans more efficient and effective in providing beneficiaries with coordinated care. In addition to lowering reimbursement for these plans so that per-beneficiary costs are more in line with traditional fee-for-service Medicare, the law rewards plans that perform well on measures of quality and patient experience and strengthens protections for beneficiaries. Brian Biles, M.D., and his colleagues at the George Washington University are analyzing the impact that the new policies have on these plans and their enrollees.

Researchers also will investigate factors that drive increases in health care costs. While it is well known that care utilization and spending by Medicare beneficiaries vary from region to region, patterns of use and spending in commercial insurance markets are not as well understood. Under a Commonwealth Fund grant, Harvard Medical School's Michael Chernew, Ph.D., is examining geographic variation in commercial spending and the correlation between commercial and Medicare spending across hospital referral regions.

Other projects will focus on modeling the impact of alternative payment system approaches, identifying examples of ACOs and similar organizations in practice, and examining public and private sector initiatives to support accountability in health care provision.

To apply for a grant from The Commonwealth Fund's
Payment and System Reform program,
visit [Applicant and Grantee Resources](#).

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